Division of Immigration Health Services **Treatment, Authorization & Consultation Form**

SEND PAPER CLAIMS TO:
Division of Immigration Health Services
VA Financial Services Center
PO Box 149345
Austin, TX 78714-9345

For EDI claim submission information and claim inquiries, please contact 1.800.479.0523

Claims must be submitted within six months from date of health service.
For proper provider claim submission information, please visit: www.icehealth.org/ProviderInfo.htm

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Please ensure all claims include the Patient Identification Information and the Authorization number.

IMPRINT OF DETAINEE ID PLATE, COMPUTER LABEL OR COMPLETE BELOW:	
Name: ANA BEATRIZ BIOCINI	Alias:
DOB: 06/30/1954	A #: 091182333
Nationality: COLOMBIA	Facility: Kern Co Jail, CA

AUTHORIZED ACTION:
Status: Denied Auth #: 200709146544 00 Authorizer: Neal Collins
Service Type: Non-Emergency
Referral Type: 99

To: (*Name and Phone to whom referral is being made)*

Dialogue of Request:

TAR request is denied per consult with DIHS staff physician
Updated by Gia Lawrence on Tuesday, September 18, 2007

F/U GYN 10/02/07 to discuss performing uterine suspension & perineal rectopexy to correct prolapsed uterus/rectum MD progress notes faxed.
Thank you!

This event's case was created by TARweb and should be verified for data correctness.

08/28/07 14:23 FAX 3262178 SURGERY CLINIC → LERDO-PRE-TRIAL 002/002

KER EDICAL CENTER
18 OWER ST.
BAK FIELD, CA. 93305

Owned & Operated by County of
CLINIC RECORD NO1

STAR ACCOUNT NO	DATE ARRIVED	TIME	ARRIVAL MODE	PATIENT TYPE	MEDICAL RECORD NO
0724100525	08/28/07	07:48	SHERIFF KERN CTY	SUR	0001178074

PATIENT
PATIENT NAME: BIOCINI, BEATRIZ ANA
STREET ADDRESS: 17635 INDUSTRIAL FARM RD
CITY: BAKERSFIELD
BIRTHDATE: 08/30/54 AGE: 53Y SEX: F
PHONE: (000)391-7913
SOC.SEC.NO: 000-00-0001
MARITAL STATUS:
STATE: CA ZIP: 00003
INS PO: BK#1709304
EMERGENCY NOTIFY: NONE AT THIS TIME
FIN/CLASS: J COUNTY CORRECTIONA
MANAGED CARE/HMO: Yes No
AUTHORIZED: Yes No
TIME:
TRIAGE CATEGORY: WALK-IN APPOINTMENT
HOME PHONE:
BUSINESS PHONE:
CHIEF COMPLAINT/PROBLEM: 130PM RED
IMMUNIZATION: UP TO DATE NOT UP TO DATE
LANGUAGE: A ENGLISH
PRIMARY CARE PHYSICIAN:
ALLERGIES: NKA

PAIN: Acute Chronic; Location; Duration; Characteristics (stabbing, dull); Pain Level: 4

WEIGHT	TEMP	PULSE	RESPIRATION	BLOOD PRESSURE	TIME	NURSE
	97.6	84	16	134/77	1300	M/A

Are you having any problems with your activities of daily living Yes No Problems ambulating? Yes No
Safe in the home? Yes No Harmed/Threatened Yes No IF yes current or past
Reported To: By:

Hx Rectal prolapse & bleeding since 4/07
reduced when sitting on toilet.
The vagina also prolapses & stress incontinence

By my exam she has rectal & vaginal prolapse
on straining. Grade 1 feel internally c/w hemorrhoids
Abd & abdominal incision no hernia (e.g. SRM)
has small tabs (vestig) & squeeze ability fair, not strong.
Looks like a candidate for a joint GYN/ CRS operation
CRS part: pericell protection vs hemorrhoidectomy vs excision/ cauterize

ASSESSMENT:

	DIAGNOSIS	ICD-9CM:
1.	Rectal prolapse	
2.	vaginal prolapse.	
3.		
4.		

PLANS/ORDERS:
1. OBGYN Clinic Thursday 1pm & Dr. Lopez
2. Will Discuss joint procedure & OBGYN/ Gen Surg.
3.
4.
5.

DOCTOR SIGNATURE
FACULTY REVIEW

DISPOSITION OTHER THAN HOME
PAGE 1 ONLY ATTACH AFTER CARE INSTRUCTIONS

Preformatted Form Approved 5008.50 1.18.2006

MEDICAL RECORDS

KERN MEDICAL CENTER
CORRECTIONAL MEDICINE DEPARTMENT

Facilities: ☐ Central Receiving ☑ Pretrial ☐ Minimum ☐ Federal

Inmate's Name Bacon Alex Bacon

Booking Number 170 7361 Location 13A 1

Starting Date 3/23/07 Ending Date Discharge

Check all that apply:

- ☐ Provide change of towels daily until _____
- ☐ Change personal clothing and bed linen daily until _____
- ☐ May use crutches/walker/wheelchair due to medical problem
- ☐ Lower bunk due to medical problem
- ☐ Lower bunk, lower tier
- ☐ Non wool blanket due to skin allergies/wool allergies
- ☐ Thermals due to medical problem
- ☐ White canvas shoes due to diabetes ☐ Foot deformities ☐
- ☐ May have own prescription glasses from home
- ☐ Double mattress due to: _____
- ☐ Provide bed location away from cooler or vents
- ☒ No shackles on (which extremity) Right wrist due to medical problem
- ☐ Seizures
- ☒ Other Denied per Dr Burns due to security

Comments: - f/u once from transportation

By: [illegible] / [illegible] Date: 3/23/07

Shift Supervisor: [illegible] # 324 Date: 3-24-07

01/27/04

Because inmate has Rectal prolapse
long time /handcuffs / waiting for transportation
uncomfortable
for inmate Please help her for
faster transfer to Hospital if possible

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Please ensure all claims include the Patient Identification Information and the Authorization number.

IMPRINT OF DETAINEE ID PLATE, COMPUTER LABEL OR COMPLETE BELOW:	
Name: ANA BEATRIZ BIOCINI	Alias:
DOB: 06/30/1954	A #: 091182333
Nationality: COLOMBIA	Facility: Kern Co Jail, CA

AUTHORIZED ACTION:
Status: Approved Auth #: 200708304365 00 Authorizer: Jennifer R. Jones
Service Type: Non-Emergency
Referral Type: 11

To: (*Name and Phone to whom referral is being made)*

Dialogue of Request:

Approve f/u GYN clinic visit x1 only.
NOTE: Request for surgical repair of vaginal and rectal prolapse was previously denied.
Updated by Jennifer R. Jones on Tuesday, **September 04, 2007**

---

f/u in GYN Clinic for consultation w/Dr. Lopez for vaginal prolapse. Discussion witl gyn/gen surg. for joint procedure fo rectal and vaginal prolapse.

This event's case was created by TARweb and should be verified for data correctness.

KE MEDICAL CENTER
18 FLOWER ST.
BAKERSFIELD, CA. 93305

Owned & Operated by County of Ke

CLINIC RECORD NOTE

STAR ACCOUNT NO: 0723200204 | DATE ARRIVED: 08/20/07 | TIME: 13 30 | ARRIVAL MODE: SHERIFF KERN CTY | PATIENT TYPE: SUR

PATIENT NAME: BIOCINI,BEATRIZ ANA | MEDICAL RECORD NO: 0001178074

STREET ADDRESS: 17635 INDUSTRIAL FARM RD | CITY: BAKERSFIELD | BIRTHDATE: 06/30/54 | AGE: 53Y | SEX: F

PHONE: (000)391-7913 | SOC SEC NO: 000-00-0001 | MARITAL STATUS | STATE: CA | ZIP: 00003

INS | POL NO: BK#1709304 | POL NO | FINANCIAL CLASS: J COUNTY CORRECTIONA

IN EMERGENCY NOTIFY: NONE AT THIS TIME

MANAGED CARE/HMO: Yes No | AUTHORIZED: Yes No | TIME | TRIAGE CATEGORY | WALK IN | APPOINTMENT | HOME PHONE | BUSINESS PHONE | IMMUNIZATION UP TO DATE | NOT UP TO DATE | LANGUAGE: A ENGLISH

CHIEF COMPLAINT/PROBLEM: 130PM RED

PAIN: Acute | Chronic | Location | Duration | Characteristic (stabbing dull) | Pain Level: 8

PRIMARY CARE PHYSICIAN | ALLERGIES: NKA

WEIGHT	TEMP	PULSE	RESPIRATION	BLOOD PRESSURE	TIME	NURSE
142	Oral	81	18	125/74	1:20	

Are you having any problems with your activities of daily living Yes (No) Problems ambulating? Yes (No)

Safe in the home? Yes No Harmed/Threatened Yes No IF yes current or past

Reported To | By

55 YO ♀ c/o rectal bleeding, rectal prolapse, vaginal prolapse. Uses Milk of Magnesia to soften stool Pt. reports light pain in rectus currently (1st notice) prolapse 1/07, got critical in april 17 months in jail. Fighting imm. gration papers Mex

PMH: Liposuction, Para 3 Gravital, last menstruation 4 months ago

SH: 20 pack years tobacco, alcohol from Colombia

Milk of Magnesia
Metamucil
lactulose

FH: MI, Moms sister stomach CA

NKDA!

PE: Lungs: CTA-B

♡: regular rhythm, 110 pulse, ⊖ g, M, r

Ab: hyperactive bowel sounds, ND, NT

Ext: ⊖ c/c/e

Additional: Pt c/o kidney pain - flank back pain, bilaterally

ASSESSMENT | DIAGNOSIS | ICD-9CM

1 Rectal prolapse

2

3

4

PLANS/ORDERS.

1 Referral to Urology Clinic 8/29 to see Dr. Cosmen

2

3

4

5

Dated 8/20/07 [illegible]

[illegible]

DOCTOR SIGNATURE

FACULTY REVIEW

DISPOSITION OTHER THAN HOME

PAGE 1 ONLY ATTACH AFTER CARE INSTRUCTIONS

BY: [illegible]

8/22/2007

MEDICAL RECORDS

9753

Patient/Family Health Education Record

#0720700277 MEDREC 0001178074
INI BEATRIZ ANA
SCR DATE 07/26/07 DOB 06/30/54 SEX F

Patient learning Questionnaire: P=Poor A=Average G=Good Circle appropriate	Patient	Other
How would you rate your ability to understand verbal instructions?	P A G	P A G
How would you rate your ability to understand written instructions?	P A G	P A G
How would you rate your knowledge of your treatment plan and educational needs?	P A G	P A G
How would you rate your willingness to learn and follow through with treatment?	P A G	P A G

Specific Barriers to Learning

Do any of the following interfere with your ability to learn? Circle y (yes) n (no)

Chronic Illness	Y N	Trouble Remembering	Y N	Cultural Beliefs	Y N
Hearing problems	Y N	Trouble understanding	Y N	Religious Beliefs	Y N
Difficulty Reading	Y N	Financial Concerns	Y N	Pain	Y N
Speaking Problem	Y N	Emotional Concerns	Y N	Visual Problem	Y N

How do you learn best? Video Verbal Written

Date 7/26/07 Signature/Title

Because violence is common in many lives, we are asking about it routinely.
Do you feel safe in your home? Y N
Have you ever been harmed or threatened by someone you live with or are close to? Y N
If yes, is it occurring currently or in the past? Currently Past

*If currently please complete the next section

Reported to _____ By _____

Date/Time _____

Date _____ Signature/Title _____

PRINTED BY: [illegible]
DATE 8/22/2007

SECTION II

EDUCATION NEEDS		WHO		HOW		RESPONSE	
CODE		CODE		CODE		CODE	
MED	Safe & effective use of medications	PT	Patient	D	Demonstration	Q	Asked Questions
EQ	Safe & effective use of equipment	F	Family	P	Pamphlet	VR	Verbalized recall/understanding
F/D	Potential food/drug/herb interaction	O	Other	TV	Video/TV	R	Resists/difficulty listening
DIET	Modified diet/nutrition			V	Verbal Instructions	DI	Seems disinterested
REHAB	Rehabilitation techniques			W	Written instructions	DR	Denial/resistance
CR	Community resources			VT	Translator	DA	Demonstrated ability
POC/DC	Plan of care/treatment services			MED	Medication instruction sheet	NR	Needs reinforcement
PM	Pain management			GR	Group Work	A	Attentive verbal response
HC	Basic health practices			O	Other	NA	Not applicable
O	Other			I	Initiate teaching education protocol	NC	No change
						NER	New education record required
				CN	Care notes		

DATE	TIME	ED NEEDS	INFORMATION TAUGHT	WHO	HOW	RESPONSE	SIGNATURE/TITLE
7/26/07	1145hr		POC/DC [illegible] Pt		V/w	V	[illegible] 1145

PRINTED BY: [illegible]
DATE: [illegible]

KERN MEDICAL CENTER
Owned and Operated by the County of Kern
Bakersfield, CA 93305

ACCT#0723200204 MRN#C 00011780?4
BIOCINI,BEATRIZ ANA
SVR DATE 08/20/07 DOB 08/30/54 SEX F

OUTPATIENT AFTERCARE INSTRUCTIONS

It is important that you follow up as directed and please report to your doctor if symptoms persist or worsen. When clinic is closed, please seek emergency care. Please bring all medications with you to every clinic visit. Medication refills: Please call at least 7 days before running out

CLEAR LIQUID DIET

___ Until the problem for which you are using this diet stops EAT ONLY
- _ Clear Soups
- _ Pedialyte, Lytren
  DO NOT DILUTE PEDIALYTE
- ___ Soft diet after liquid diet for 6 hours. No raw vegetables or fruits

VOMITING

___ Clear liquid diet (see above) but in frequent small amounts only
___ Watch for signs of dehydration (see below)
___ Call your doctor if you notice blood in the vomitus

DIARRHEA

___ Clear liquid diet (see above)
___ If not vomiting and keeps clear liquids down you may try fresh ripe bananas that have been mashed. Also dried toast may be tried
___ Call the MD if you see blood in the diarrhea
___ Watch for signs of dehydration (see below)
___ Return to Clinic sooner or ___ to ER ___ call us if
- ___ Fever or _____ not better in 3 days
- ___ Chest pains

WOUND CARE

___ Keep wound covered until rechecked
___ If dressings get wet or dirty you should
- ___ change them ___ call your MD or the ER

___ Leave wound open to the air
___ You may wash the wound after _____ days
___ Return for wound check in _____ days
___ Sutures to be removed in _____ days
___ Limit movement of the affected part
___ Elevate the injured part higher than your heart, to decrease swelling and improve healing for ___ hours
___ Cool packs to the area to prevent swelling and pain for _____ hours

DESPITE THE GREATEST CARE, ANY WOUND CAN BE INFECTED. RETURN IMMEDIATELY OR SEE YOUR DOCTOR IF SIGNS OF REDNESS, SWELLING, PUS OR RED STREAKS OCCUR, OR IF THE WOUND FEELS MORE SORE INSTEAD OF LESS SORE AS THE DAYS GO BY

DEHYDRATION Signs to look for
___ Decreased urine flow
___ Very sleepy, hard to wake up
___ Dizziness when standing up
___ Very dry mouth
___ No tears seen when patient cries

OTHER INSTRUCTION SHEETS
___ English ___ Spanish

___ Anemia
___ Angina/Heart Diseases
___ Asthma
___ Back/Neck Injury
___ Bowel Prep for Endoscopy
___ Bronchitis
___ Cancer Pamphlets
___ Care of Foreskin
___ Cast Care
___ Cholesterol diet
___ Breast Cancer
___ Breast Self Exam
___ Chest Injury
___ Chest Wall Pain
___ Chicken Pox
___ Child Proofing
___ Cold/Flu
___ Congestion
___ Conjunctivitis
___ Constipation
___ Contraception
___ Contusions
___ Croup
___ Diabetes
___ Diet/Nutrition
___ Ear Infections
___ Endometrial Curettage
___ Enuresis
___ Epididymitis

DISPOSITION
___ You may return to work
___ You may not return to work Until _____
___ You may return to light work
- ___ immediately
- ___ on _____

___ No school until _____
___ No physical education Until _____

___ Febrile Seizures
___ Fetal Movement Count
___ Flex Sigmoidoscopy
___ Gallbladder Disease
___ Gastritis
___ Gastroscopy Instructions
___ GI Reflux diet
___ Head Injury
___ Hepatitis
___ Hypertension
___ Impetigo
___ Inhaler
___ Kidney Stones
___ Lice
___ Low back pain exercise
___ NST Biophysical Profile
___ Pneumonia
___ Pregnancy
___ Pyelonephritis
___ Reflux Esophagitis
___ SBE Prophylaxis
___ Scabies
___ Sinusitis
___ Smoking Cessation
___ Sprain/Fracture Care
___ STD's/PID
___ Threatened Abortion
___ Tobacco Preventions
___ UTI's
___ Vaginitis

Tests Ordered: Please call to schedule appointment 326-3800 for appt

Patient Education
Learning needs/abilities assessed
Specify: none
Barriers to learning
Specify: _____

Follow up/ Additional Instructions: Patient to come on Wednesday 8/29/07 to see Dr. Cooper in Urology clinic

I have received as well as demonstrated my understanding of the discharge instructions given

Patient Signature: Pt left without discharge Time: 1630 hrs

Exit Interviewer Signature: [illegible] Physician Signature: [illegible]

DATE: 8/22/2007

Victor J Rosario

KMC 580-8997 1865 Rev 1/01
KMC Stock # 1404/0

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IMPRINT OF DETAINEE ID PLATE, COMPUTER LABEL OR COMPLETE BELOW:	
Name: ANA BEATRIZ BIOCINI	Alias:
DOB: 06/30/1954	A #: 091182333
Nationality: COLOMBIA	Facility: Kern Co Jail, CA

AUTHORIZED ACTION:
Status: Approved Auth #: 200708212886 00 Authorizer: Jennifer R. Jones
Service Type: Non-Emergency
Referral Type: 11

To: *(Name and Phone to whom referral is being made)*

Dialogue of Request:

Approve urology consult x1.
Approved for consult only. Please submit treatment plan and clinical assessment i other care recommended.
Updated by Jennifer R. Jones on Wednesday, August 22, 2007

Urology Appt. 8/29/07, per surgeon inst. to see urologist due to inmate c/o kidne pain-flank back pain, bilaterally.

This event's case was created by TARweb and should be verified for data

KER[illegible]EDICAL CENTER
183[illegible] LOWER ST.
BAKERSFIELD, CA. 93305

Owned & Operated by County of Kern

CLINIC RECORD NOTES

STAR ACCOUNT NO: 0720700277	DATE ARRIVED: 07/26/07	TIME: 12:30	ARRIVAL MODE: SHERIFF KERN CTY	PATIENT TYPE: SUR	MEDICAL RECORD NO: 0001178074

PATIENT
NAME: BIOCINI,BEATRIZ ANA
STREET ADDRESS: 17835 INDUSTRIAL FARM RD
CITY: BAKERSFIELD
STATE: CA
ZIP: 00003
PHONE: (000)391-7913
SOC SEC NO: 000-00-0001
MARITAL STATUS:
BIRTH DATE: 06/30/54
AGE: 53Y
SEX: F
INS. PLC YO: BOOKING 1709304
PDI NO:
FINANCIAL CLASS: J COUNTY CORRECTIONA
IN EMERGENCY NOTIFY: NONE AT THIS TIME
HOME PHONE NO:
BUS NESS PHONE NO:
Pre-trial immigration
MANAGED CARE? ☐ Yes ☐ No
AUTHORIZED: ☐ Yes ☐ No
TIME:
TRIAGE CATEGORY:
☐ WALK IN ☐ APPOINTMENT
IMMUNIZATION UP TO DATE: ☐ NOT UP TO DATE:
LANGUAGE: A ENGLISH
CHIEF COMPLAINT/PROBLEM: ROUTINE SURG CLN RED 1230P
PRIMARY CARE PHYSICIAN:
ALLERGIES: NKA

PAIN: ☐ Acute ☐ Chronic
Location:
Duration:
Characteristic (stabbing, dull):
Pain Level: 5

WEIGHT	TEMP	PULSE	RESPIRATION	BLOOD PRESSURE	TIME	NURSE
141	97.1	86	18	116/79	1:05	

Are you having any problems with your activities of daily living Yes (No) Problems ambulating? Yes (No)
Safe in the home? (Yes) No Harmed/Threatened Yes No IF yes current or past
Reported To: C. Stiles By: Beatriz Ana Biocini

cp and ~~93 y/o f c/o rectal bleeding~~ + rectal prolapse + pain 10/10
F/U for colonoscopy on 6/15 internal hemorrhoids found. Pt. still bleeding.

53 y/o f c/o rectal bleeding + rectal prolapse + pain 10/10 for ~ 1 yr. needs to use enema and softeners to ft. chart deficate
lungs: CTAB
heart: RRR, MΦ
abdomen: ⊕BS, soft, ND
allergies: Φ NKDA: metamucil, colace, milk of magnesia
PMH: Φ
smoking: Φ
Etoh: Φ

ROS = rectal prolapse 87 lbs since ~ 1 yr ago
BBS incontinence

ASSESSMENT: **DIAGNOSIS** **ICD-9CM:**

1. Rectal prolapse
2. Vaginal Prolapse
3. Stress incontinence
4.

PLANS/ORDERS:

1. Return 8/20/07 (1st item) Prior to Procedure
2. 3 AM for prolapse repair
3.
4.
5.

Rec'd 7/26/07 1415 hrs

DOCTOR SIGNATURE

DISPOS: ON OTHER THAN HOME

PAGE 1 ONLY ATTACH AFTER CARE INSTRUCTIONS

FACILITY REVIEW

PRINTED BY: 101116

DATE: 7/26/07 486

8/22/2007
MEDICAL RECORDS

ATTENDING NOTE:

HX:

PE.

LAB/XRAY:

IMPRESSION:

PLAN:

PATIENT BIOCINI,BEATRIZ ANA ACCT # 0720700277 MEDREC# 0001178074 ADMIT DATE: 07/26/07 ADMIT TIME 12:30

SIGNATURE

ATTENDING NOTE/ATTESTATION:

☒ I have examined and evaluated the patient. I have reviewed the resident's note and agree with the plan of care. I have discussed this with the resident.

☐ I have examined and evaluated the patient. I have reviewed the resident's note and agree with the plan of care **except as noted below.** I have discussed this with the resident.

PRINTED BY: [illegible]

DATE: 8/22/2007

Q INS Auth Only OK | 7.27.07 Cgl ✓

JC 1720700277 MEDREC 0001178074
BIO BEATRIZ ANA
SUR DATE: 07/26/07 DOB 08 30 64 SEXF

KERN MEDICAL CENTER
Owned & Operated by County of Kern

Case Management Department

SURGERY AUTHORIZATION REQUEST

[ ] Emergent – *Approval needed within three (3) days*
[ ] Urgent – *Approval needed within ten (10) days*
[X] Elective

Diagnosis: Rectal prolapse

Medical Justification: Recent incarceration
Bowel resection (LAR vs PAR)

Planned Procedure: Bowel resection (low anterior resection vs APR) Trans anal resection) for rectal prolapse

Outpatient [ ] Inpatient [X] **Expected Length of Stay:** 4 Days

Booking # 1709304

Resident: Thomas
Chief/Senior Resident:
Staff: Cosmas Tayla

Date: 7/26/07
Team: Red
Service:

Case Management Department Response

Date: 7.27.07

[X] **OK to Schedule**

[ ] **Approved by:** MCal GK GN CCS Other

Outpatient Inpatient (LOS_____) **Auth Expires:**

[ ] **Deferred/Denied – Reason:**

[X] **TAR Not Needed**

[ ] *Medi-Cal Restricted – Will Not Cover Elective Procedures. Requires Administration Approval.*

KERN MEDICAL CENTER
Owned and Operated by the County of Kern
Bakersfield, CA 93305

ACCT#0720700277 MEDREC 00011780/4
OCINI BEATRIZ ANA
SUR DATE: 07/26/07 DOB: 08/30/54 SEX:

OUTPATIENT AFTERCARE INSTRUCTIONS

It is important that you follow-up as directed and please report to your doctor if symptoms persist or worsen. When clinic is closed, please seek emergency care. Please bring all medications with you to every clinic visit. Medication refills: Please call at least 2 days before running out.

☐ **CLEAR LIQUID DIET**

___ Until the problem for which you are using this diet stops, EAT ONLY:
___ Clear Soups
___ Pedialyte, Lytren
DO NOT DILUTE PEDIALYTE
___ Soft diet after liquid diet for 6 hours. No raw vegetables or fruits

☐ **VOMITING**

___ Clear liquid diet (see above) but in frequent small amounts only
___ Watch for signs of dehydration (see below)
___ Call your doctor if you notice blood in the vomitus

☐ **DIARRHEA**

___ Clear liquid diet (see above)
___ If not vomiting and keeps clear liquids down you may try fresh ripe bananas that have been mashed. Also dried toast may be tried.
___ Call the MD if you see blood in the diarrhea
___ Watch for signs of dehydration (see below)
___ Return to Clinic sooner or ___ to ER ___ call us if
___ Fever or _____ not better in 3 days
___ Chest pains

☐ **WOUND CARE**

___ Keep wound covered until rechecked
___ If dressings get wet or dirty you should
___ change them ___ call your MD or the ER
___ Leave wound open to the air
___ You may wash the wound after _____ days
___ Return for wound check in _____ days
___ Sutures to be removed in _____ days
___ Limit movement of the affected part
___ Elevate the injured part higher than your heart, to decrease swelling and improve healing for ___ hours
___ Cool packs to the area to prevent swelling and pain for _____ hours

DESPITE THE GREATEST CARE, ANY WOUND CAN BE INFECTED. RETURN IMMEDIATELY OR SEE YOUR DOCTOR IF SIGNS OF REDNESS, SWELLING, PUS OR RED STREAKS OCCUR, OR IF THE WOUND FEELS MORE SORE INSTEAD OF LESS SORE AS THE DAYS GO BY.

☐ **DEHYDRATION:** Signs to look for
___ Decreased urine flow
___ Very sleepy, hard to wake up
___ Dizziness when standing up
___ Very dry mouth
___ No tears seen when patient cries

OTHER INSTRUCTION SHEETS
___ English ___ Spanish

___ Anemia
___ Angina/Heart Diseases
___ Asthma
___ Back/Neck Injury
___ Bowel Prep for Endoscopy
___ Bronchitis
___ Cancer Pamphlets
___ Care of Foreskin
___ Cast Care
___ Cholesterol diet
___ Breast Cancer
___ Breast Self Exam
___ Chest Injury
___ Chest Wall Pain
___ Chicken Pox
___ Child Proofing
___ Cold/Flu
___ Congestion
___ Conjunctivitis
___ Constipation
___ Contraception
___ Contusions
___ Croup
___ Diabetes
___ Diet/Nutrition
___ Ear Infections
___ Endometrial Curettage
___ Enuresis
___ Epididymitis
___ Febrile Seizures
___ Fetal Movement Count
___ Flex Sigmoidoscopy
___ Gallbladder Disease
___ Gastritis
___ Gastroscopy Instructions
___ Gt Reflux diet
___ Head Injury
___ Hepatitis
___ Hypertension
___ Impetigo
___ Inhaler
___ Kidney Stones
___ Lice
___ Low back pain exercise
___ NST Biophysical Profile
___ Pneumonia
___ Pregnancy
___ Pyelonephritis
___ Reflux Esophagitis
___ SBE Prophylaxis
___ Scabies
___ Sinusitis
___ Smoking Cessation
___ Sprain/Fracture Care
___ STD's/PID
___ Threatened Abortion
___ Tobacco Preventions
___ UTI's
___ Vaginitis

☐ **DISPOSITION**
___ You may return to work
___ You may not return to work
Until ___
___ You may return to light work
___ immediately
___ on _____
___ No school until _____
___ No physical education
Until _____

Tests Ordered: SAR Submitted for approval

Patient Education
☐ Learning needs/abilities assessed
Specify: none
☐ Barriers to learning
Specify _____

Follow-up/Additional Instructions: Return to Med Surgery Mon Aug 20, 07 1:00 pm

I have received as well as demonstrated my understanding of the discharge instructions given.

Patient Signature: [signature] Time: 1415 Pm

Exit Interviewer Signature: [signature] Physician Signature: [signature]

DATE: 07/27/07

KMC 460 (8/97) 1865 (Rev 11/01)
KMC Stock # 140470

Division of Immigration Health Services **Treatment, Authorization & Consultation Form**

SEND PAPER CLAIMS TO:
Division of Immigration Health Services
VA Financial Services Center
PO Box 149345
Austin, TX 78714-9345

For EDI claim submission information and claim inquiries, please contact 1.800.479.0523

Claims must be submitted within six months from date of health service.
For proper provider claim submission information, please visit: www.icehealth.org/ProviderInfo.htm

A separate treatment authorization request will be required for services beyond and outside the scope of the original authorization. Services rendered may not be paid without an approved authorization. All payment for services is subject to detainees' eligibility and custody. Unless otherwise specified, payment for DIHS' authorized health services is made in accordance with US Code Title 18, Part 3, Chapter 301, Sec. 4006. For all non-emergency authorized health services this TAR is valid for 45 days after the date of issue and cannot be used for health services rendered prior to the date of issue. All claims are subject to retrospective review. For further information regarding DIHS, please visit our website: www.icehealth.org or contact the Immigration Health Services' Managed Care Branch at 1.888.718.8947, M-F 8AM - 6PM EST.

Please ensure all claims include the Patient Identification Information and the Authorization number.

IMPRINT OF DETAINEE ID PLATE, COMPUTER LABEL OR COMPLETE BELOW:	
Name: ANA BEATRIZ BIOCINI	Alias:
DOB: 06/30/1954	A #: 091182333
Nationality: COLOMBIA	Facility: Kern Co Jail, CA

AUTHORIZED ACTION:
Status: Denied Auth #: 200707279367 00 Authorizer: Neal Collins
Service Type: Non-Emergency
Referral Type: 21

To: (*Name and Phone to whom referral is being made)*

Dialogue of Request:

Clinical information submitted to the DIHS Staff MD.
Based upon the information submitted, the request for elective surgical rectal anc vaginal prolapse repair is denied.
Updated by Claudia Mazur, RN, CCM on Tuesday, July 31, 2007

Division of Immigration Health Services **Treatment, Authorization & Consultation Form**

SEND PAPER CLAIMS TO:
Division of Immigration Health Services
VA Financial Services Center
PO Box 149345
Austin, TX 78714-9345

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Please ensure all claims include the Patient Identification Information and the Authorization number.

IMPRINT OF DETAINEE ID PLATE, COMPUTER LABEL OR COMPLETE BELOW:	
Name: ANA BEATRIZ BIOCINI	Alias:
DOB: 06/30/1954	A #: 091182333
Nationality: COLOMBIA	Facility: Kern Co Jail, CA

AUTHORIZED ACTION:
Status: Approved Auth #: 200708141874 00 Authorizer: Neal Collins
Service Type: Non-Emergency
Referral Type: 11

To: (*Name and Phone to whom referral is being made*)

Dialogue of Request:

Approve follow up MD exam on 8-20-07. At that time, I will need, the exact proposed surgical procedure, the date and name of the hospital, the name and phone number of the MD.
Updated by Claudia Mazur, RN, CCM on Thursday, August 16, 2007

Diagnosis: rectal prolapse. Medical justification: present ulceration, bowel resectic (LAR vs TAR). Planned Procedure Bowel Resection/lower anterior resection vs trai

KERN MEDICAL CENTER
1830 FLOWER ST.
BAKERSFIELD, CA. 93305

CLINIC RECORD NOTES

ACCOUNT NO 0718000403 | DATE ARRIVED 06/29/07 | TIME 04:12 | ARRIVAL MODE SELF | PT CLASS | LOCATION | MEDICAL RECORD NO 0001178074

PATIENT NAME BIOCINI,BEATRIZ ANA | BIRTHDATE 06/30/54 | AGE 52Y | SEX F

ADDRESS 17835 INDUSTRIAL FARM RD | CITY BAKERSFIELD | STATE CA | ZIP 00003

PHONE (000)391-7913 | SOCIAL SEC NO 000-00 0001 | MARITAL STATUS | FINANCIAL CLASS J COUNTY CORRECTIONA

INS NO | PCL NO BK#1709304 | KIN NO | POLICY NO

EMERGENCY NOTES NONE AT THIS TIME | HOME PHONE | BUSINESS PHONE

MANAGED CARE/HMO ☐ YES ☐ NO | AUTHORIZED ☐ YES ☐ NO | TIME | HMO PERSON AUTHORIZING | TETANUS IMMUNIZATION ☐ UP TO DATE ☐ NOT UP TO DATE | LANGUAGE A ENGLISH

CONDITION UPON ARRIVAL ☐ CONSCIOUS ☐ UNCONSCIOUS | CHART ORDERED TIME (IF NOT A ED) | TIME RECEIVED (IF INDICATED) | TRIAGE CATEGORY ☐ WALK IN ☐ APPOINTMENT ☐ TIME CRITICAL ☐ URGENT ☐ EMERGENCY ☐ ISOLATION ☐ SHOP ☐ OB

CHIEF COMPLAINT/PROBLEM 701A COLN APPT | PRIMARY CARE PHYSICIAN | ALLERGIES

OBJECTIVE FINDING | WEIGHT | HEIGHT | TEMP | PULSE | BLOOD PRESSURE | RESPIRATION | HEAD CIRCUM | NURSE/ORTHO TECH

TIME SEEN: 1000

For colonoscopy, 2° BRBPR & prolapse. No previous colonoscopy.

Good prep up to mid transverse. Redundant sigmoid. → Ventrad to cecum grossly & worries & diverticula (R) internal hemorrhoid & external hemorrhoid & prolapse identified

A/P internal hemorrhoid, transient bleeding
Subjective prolapse
- May resume regular high fiber diet
- Metamucil daily x 30 days
- Follow up in Red Surgery Clinic 2 weeks.

Dictated 6/29/07

DISABILITY | FINAL DIAGNOSIS internal hemorrhoid

DOCTOR'S SIGNATURE | SPOUSE OR OTHER THAN HOME

FACILITY REVIEW | PAGE 1 ONLY ATTACH AFTER CARE INSTRUCTIONS

DATE 6/29/2007

MEDICAL RECORDS

KERN MED[illegible] CENTER
Owned & Operated by County of Kern
Bakersfield, CA

ACCT# 07180004 SSN: 000 00-0001 MEDREC# 0001178074
PATIENT BIOCINI, BEATRIZ ANA DOB: 8/30/1964
17636 INDUSTRIAL FARM RD
BAKERSFIELD CA 00003 ADMIT DT: 06/29/07

VALIDATION OF CONSENT FOR SURGERY OR SPECIAL PROCEDURE

1. Your physician and surgeons have recommended the operation or procedure, set forth below. Upon your authorization and consent, this operation or procedure, together with any different or further procedures, which in the opinion of the supervising physician or surgeon may be indicated due to any emergency, will be performed on you. The operations or procedures will be performed by the supervising physician or surgeon named above (or in the event of an unforeseen absence of the above named physician, of if he/she is unable to perform or complete the procedure, a qualified substitute supervising physician or surgeon), together with associates and assistants, including anesthesiologists, pathologists and radiologists from the medical staff of Kern Medical Center to whom the supervising physician or surgeon may assign designated responsibilities. The hospital maintains personnel and facilities to assist your physicians and surgeons in their performance of various surgical operations and other special diagnostic or therapeutic procedures.

2. These operations and procedures carry the risk of unsuccessful results, complications, injury, or even death, from both known and unforeseen causes, and no warranty or guarantee is made as to result or cure. You have the right to be informed of such risks as well as the nature of the operation or procedure, the expected benefits or effects of such operation or procedure, and the available alternative methods of treatment and their risks and benefits. You also have the right to be informed whether your physician has any independent medical research or economic interests related to the performance of the proposed operation or procedure. Except in cases of emergency, operations or procedures are not performed until you have had the opportunity to receive this information and have given your consent. You have the right to consent to or to refuse any proposed operation or procedure at any time prior to its performance.

3. If your physician determines that there is a reasonable possibility that you may need a blood transfusion during the operative/perioperative treatment as a result of the operation or procedure to which you are consenting, your physician will inform you of this and will provide you with a brochure regarding blood transfusions. ***This does not apply when medical contraindications or a life-threatening emergency exists.*** This brochure contains information concerning the benefits and risks of the various options for blood transfusions, including predonation by your self or others. You also have the right to have adequate time before your procedure to arrange for predonation, but you can waive this right if you do not wish to wait. If you decide to wait you should discuss this fact with your physician. You should understand that transfusions of blood or blood products involve certain risks, including the transmission of disease such as hepatitis or Human Immunodeficiency Virus (HIV) and that you have a right to consent or refuse consent to any transfusion. You should discuss any questions that you may have about transfusions with your physician.

4. To make sure that you fully understand the operation or procedure, your physician has fully explained the operation or procedure to you before you decide whether or not to give consent. If you have any questions, you are encouraged and expected to ask them before you sign this form. If you think of any questions later, contact your supervising physician or surgeon, who will be happy to answer them.

5. Kern Medical Center is a teaching institution. Under the supervision of the attending physician, persons who are residents and medical students may participate in your care as part of the medical education program of the institution.

PRINTED BY: [illegible]
DATE: 8/22/2007

ACCT# 0718000403 SSN 000 00 0001 MEDREC #0001178074
PATIENT BIOCINI BEATRIZANA DOB 6/30/1964

VALIDATION OF CONSENT FOR SURGERY OR SPECIAL PROCEDURE

6 Your signature on this form indicates that (1) you have read and understood the information provided in this form; (2) the operation or procedure, and its risks, benefits and alternatives have been adequately explained to you by your physician; (3) you have had a chance to ask your doctor(s) questions; (4) you have received all of the information you desire concerning the operation or procedure; (5) you authorize and consent to the performance of the operation or procedure; and (6) you authorize and consent to the administration of anesthesia as deemed appropriate by the anesthesiologist

Your supervising physician or surgeon is: Drs Wong, Charles, Chung, Ray

Operation(s) and/or procedures: Colonoscopy with conscious sedation, possible biopsies, polypectomies and control of bleeding

SIGNATURE: x Ana B Biocini (patient/parent/conservator/guardian) DATE: 6/29/07 TIME: 915

Relationship (if signed by other than patient):

Interpreter: _____ Title/Relationship: _____ (employee, family, friend)

BB (Nurse Initials) I have reviewed and verified that the physician has documented the informed consent, to include, the discussion with the patient of risk, benefits, and alternatives, and that the patient has consented for the above named procedure.

Authorized Employee Witness: [signature]

Authorized Employee Witness: _____ (second witness required if phone consent)

PRINTED BY: [illegible]
DATE: 8/22/2007

KERN MEDICAL CEN
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Bakersfield, CA

ACCT # 071806...03 MEDREC # 0001178074
PATIENT BIOCINI, BEATRIZ ANA
ADMIT DT 06/29/07 DOB 6/30/1954

POST ENDOSCOPY ORDERS (Outpatients)

ONLY CHECKED ORDERS WILL BE INITIATED PAGE 1 OF 1

Doctor: WONG CHUNG

Diagnosis: INTERNAL HEMORRHOID / PROLAPSE

- [X] 1. Admit to Diagnostic Treatment Center
- [X] 2. Vital Signs: ✓ Per Conscious Sedation Policy
  _____ Every _____ minutes times _____
  Call MD if pulse rises by more than 15 initially or BP falls by more than 15mmHg systolic 10 mmHg diastolic compared to baseline vital signs
- [ ] 3. IV Fluids: ☐ D5W ☐ NS ☐ Heplock ☐ Other (specify)_____ @ _____ ml per hour
  ☒ Discontinue IV
- [X] 4. Diet: NPO until patient is able to swallow
  Clear liquid diet before discharge
  May resume normal diet as tolerated 1 hours after procedure
- [X] 5. Activity: As tolerated
- [X] 6. Discharge per discharge criteria. Discharge patient to exit via wheelchair
- [ ] 7. Contact Dr. THOMAS at # 24560 if any problem occurs.

Signature _____ T372 M.D. Date/Time: 6/29/07 1006

Noted by: _____ 77849 R.N. Date/Time: 6/29/07 1005

Owner: DTC
Approved by Medical Records Committee 10/03
(MC 520 599/ 2113 (8/03))

PRINTED BY: [illegible]
DATE 8/22/2007

[illegible]

[illegible]

KERN MEDICAL CENTER
1830 Flower Street
Bakersfield, CA [illegible]
[illegible]

PROCEDURE NOTE

PROCEDURE DATE:

ACCOUNT #: [illegible]

PATIENT NAME	PHYSICIAN	UNIT #
[illegible]INO, BEATRIZ ANA	Charles Wong, D.O.	[illegible]

DATE OF PROCEDURE: 06/[illegible]/2007

SURGEON: Charles Wong, D.O.
STAFF: Ray Chung, M.D.

ANESTHESIA: Procedural sedation 50 mg of Demerol and 2 mg of Versed.

ESTIMATED BLOOD LOSS: None.

COMPLICATIONS: None.

INDICATIONS: This is a 52-year-old female with history of rectal prolapse that has been problematic for six to seven months. The patient notes that she has to manually reduce the prolapse after a bowel movement. The patient has been taking Milk of Magnesia chronically to soften her stools and does not experience any bleeding or prolapse, but has significant incontinence.

TECHNIQUE: The patient was placed in the left lateral recumbent position. She was given the above procedural sedation. An Olympus colonoscope was inserted into the rectum after digital exam showed no masses or anal stricture. The colonoscope was advanced to the level of the cecum after significant effort to navigate the redundant sigmoid. The bowel prep was very clean up until the mid transverse and then visualizing the wall became increasingly difficult. The cecum was reached and grossly there was no mass or polyp or diverticula noted. Withdrawing the scope revealed no masses or polyps or diverticula either. The colon was deflated. Upon retroflexion, internal hemorrhoid was noted, which was slightly inflamed, but not actively bleeding. The patient tolerated this procedure well without complications.

She will be discharged back to custody to follow up in the Red Surgery [illegible] in two weeks. She will be given a prescription for Metamucil daily

PRINTED BY: [illegible]
DATE 07/2[illegible]/2007

PATIENT NAME [illegible] AN [illegible]

[illegible]INI, BEATRI[illegible] ANA [illegible] Wong, D.O. [illegible]

[illegible]

[illegible] Wong, [illegible]

[illegible] By

[illegible] Wong, D.O. [illegible]

[illegible] Signature by Attending [illegible]

Page 2 of 2

Authenticated by [illegible] Wong, D.O. On [illegible]/26/0[illegible] [illegible]:39:50 AM

PRINTED BY: [illegible]

DATE [illegible]

KERN MEDICAL CEN
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ACCT# 071800[illegible]03 MEDREC# 0001178074
PATIENT BIOCINI, BEATRIZ ANA
ADMIT DT 06/29/07
DOB 6/30/1954

PRE-PROCEDURE "TIME OUT" VALIDATION

(This section MUST be completed for ALL invasive procedures performed outside the OR)

☐ Emergency procedure	☑ Patient identification verified
☑ "Risks, Benefits, Alternatives" on chart	☐ Radiologic and/or pathology reports present
☑ Consent Validation	☑ Correct equipment/supplies available
☐ Site marking present	☑ Correct site/side
Procedure: Colonoscopy	**Procedure performed by: (Name)** Dr Wong
Signature: [illegible] RN M1000	**Date:** 6/29/07 **Time:** 915

PROCEDURE FORM **Service:**

☐ Central Line: ☐ Right ☐ Left ☐ Ultrasound guided ☐ Internal Jugular (anterior, middle, posterior) ☐ Subclavian ☐ Femoral

☐ Intubation ☐ elective ☐ emergent ☐ fiberoptic ☐ Rapid Sequence Intubation

☐ Lumbar Puncture ☐ sitting ☐ lying Opening pressure _____ Closing Pressure _____

☐ Thoracestesis: ☐ Right ☐ Left ☐ diagnostic ☐ therapeutic ☐ ultrasound guided

☐ Paracentesis: ☐ Right ☐ Left ☐ diagnostic ☐ therapeutic ☐ ultrasound guided

☐ Other Procedure:

Indication for Procedure:

Sterile technique observed: ☐ No ☐ Yes (☐ gown ☐ gloves ☐ mask ☐ hat)

Analgesia: ☐ None ☐ Local ☐ Spinal ☐ Epidural ☐ Regional ☐ Procedural Sedation

Outcome: ☐ successful ☐ unsuccessful

Problems/Complications:

Supervising Attending: **Department:**

Type of Supervision: ☐ Direct ☐ Indirect (authorized & aware)

Teaching Assistant:

Signature of person completing form: **ID#:**

PRINTED BY: [illegible]

KMC 319 Owner: Joint [illegible] Approved by [illegible] (Originated 11/22/2005)

KERN MEDICAL CENTER
Owned & Operated by County of Kern
Bakersfield, CA

ACCT # 0718000403
PATIENT BIOCINI, BEATRIZ ANA
ADMIT DATE: 06/29/07

MRN # 0001178074
DOB 06/30/54

NURSING PROCEDURAL SEDATION RECORD

Patient ID

PRE PROCEDURAL ASSESSMENT

Date: 6/29/07 | Time: 740 | Procedure: Colonoscopy
Location: DTC | Person Performing Procedure: Chung Wong
☐ Inpatient ☒ Outpatient ☒ ID band on
Weight: Kg 101/45 | Age | Primary Language: Translator needed: ☒ No ☐ Yes
Belongings: ☐ Glasses ☐ Contacts ☐ Dentures ☐ Hearing aid(s) ☐ Other:
Allergies: ☒ None
Determine last solid intake: 6/27/07 | Date/time last fluid intake: 1030P 6/28 | Notify MD if below not met: Cl liq > 2 hrs, Food > 4 hrs
Current Medications: Aspirin: ☒ No ☐ Yes Anticoagulants: ☒ No ☐ Yes NSAID: ☒ No ☐ Yes Anticonvulsants: ☒ No ☐ Yes
List:
Previous sedation: ☒ No ☐ Yes. Drug: Date: '92
Previous problems with sedation/anesthesia: ☒ No ☐ Yes (specify):
Medical History: ☒ None ☐ Attention Deficit Disorder ☐ Asthma/other lung disease ☐ Apnea ☐ Congenital Cardiac Disease ☐ Cold, flu, or fever in the last 3 days ☐ Developmental delay ☐ Diabetes ☐ Heart Disease ☐ Hypertension ☐ Prematurity ☐ Seizures ☐ Skin rashes ☐ Stroke ☐ Uses Apnea monitor at home ☐ Liver disease
Other:
Lab tests done: ☒ None ☐ CBC ☐ PT/PTT ☐ UA ☐ Pregnancy test Other:
☒ Evidence of informed consent documented Validation of consent signed ☒ Yes
☐ Pre-procedural H & P done
Transportation arranged with: (name & tel. no.) Officer Inmate - Kroman - here.
☐ Pre-procedure teaching done and ☐ patient, ☐ responsible adult _____ understand instructions and information given.
Physical Assessment: Neurological: ☐ Alert, age appropriate orientation OR ☐ Usual Waking State (describe):
Respiratory: ☒ Lungs clear bilaterally ☒ No nasal congestion/cough/URI symptoms Other:
Cardiovascular: ☐ Heart rate regular ☒ Extremities warm Other:
Pain (specify location and rating according to established scales): 4/10
Pediatric Developmental Tasks: ☒ Walks independently ☐ Age appropriate speech ☐ Good head control ☐ Sits unassisted
Other findings: ☐ Cap refill < 3 sec (< 2 sec. Peds) Other:
☐ Pre-sedation vital signs and Aldrete scores documented on page 2 ☒ No abnormal findings/no change from pre-procedural MD assessment
☐ Abnormal findings reported to (MD):
Assessment completed and reviewed by: _____ RN

INTAKE & OUTPUT

☒ IV Started @ 750 gauge: 22g site: RH init: NS

INTAKE

Time	PO/IV/Fluid type/rate	Amount	Total
900	Normal Saline	500	100cc
	Cranberry Juice	120	120cc

OUTPUT

Time	Type	Amount	Total
	BRPx1		

MEDICATIONS

Time	Medication and Dose	Route	Given by	Reason (PRNs)	Effect (+/-)
917	Demerol 25mg	IV	JC	Sedation	+
917	Versed 1mg	IV	JC	Sedation	+
922	Demerol 25mg	IV	JC	Sedation	+
922	Versed 1mg	IV	JC	Sedation	+

Assessment reviewed and will proceed as planned: _____ MD
Physician's signature constitutes order for above medications.
Original – Medical Record
DATE 8/22/2007

AN I:\KMCFORMS\NURS PROCEDURAL SEDATION2 LON.DOC 5/24/04

Replaces 2/3rd Carbon 8/00 SG 8/6/2001

ACCT # 0719000403
PATIENT BIOCINI,BEATRIZ ANA

MEDREC# 0001178074
DOB 08/30/64

VITAL SIGNS

	Pre Procedure	Pre Sedation	Intra Procedure			Post Procedure				Discharge Home
TIME:	740	915	923	925	935	940	950	955	1005	1025
Blood Pressure	122/80	122/71	142/82	136/72	135/80	102/50	85/39	124/50	120/50	127/77
Temperature°	98.5									
Heart Rate	80	79	77	76	78	74	73	73	77	70
Resp. Rate	18	13	18	18	18	14	18	18	18	18
SpO2	98%	97%	97%	96%	97%	96%	98%	98%	99%	99%
Supp. O2	RA	RA	RA	RA	RA	2LNC	2LNC	2LNC	RA	RA
L.O.C.	AW	AW	AW	AW	AW	AW	AW	AW	AW	AW
Pain (0 - 10)	7/10	7/10	7/10	0	0	0	0	0	0	0
Anxiety	A	A	A	A	A	A	A	A	A	A
	C	C	C	C	C	C	C	C	C	C

ALDRETE SCORING CRITERIA

		TIME	ADM	DSC
ACTIVITY	Able to move 4 extremities voluntarily or on command	2		
	Able to move 2 extremities voluntarily or on command	1		
	Able to move 0 extremities voluntarily or on command	0	2	2
RESPIRATION	Able to breathe deeply and cough freely	2		
	Dyspnea or limited breathing	1		
	Apneic / needs ventilation or assisted	0	2	2
CIRCULATION	BP ± 20% of pre-anesthetic level	2		
	BP ± 20-49% of pre anesthetic level	1		
	BP ± 50% of pre-anesthetic level	0	2	2
CONSCIOUSNESS	Fully awake	2		
	Arousable on calling	1	2	
	Not responding	0		2
O_2 SATURATION	Able to maintain O_2 saturation > 92% on room air	2		
	Needs O_2 inhalation to maintain O_2 saturation > 90%	1	2	2
	O_2 saturation < 90% even with O_2 supplement	0		
		TOTAL	10	10

KEY

*with initial set of Vital Signs

Level of Consciousness (L.O.C.)
AW = Awake
E = Easy to Arouse
NR = Not Responding

Responsiveness:
A = Appropriate
N = Not appropriate

Anxiety: R = Restless, agitated
C = Calm, relaxed

INTRA PROC

DX TESTS

TIME	TYPE	TIME	TYPE	TIME	TYPE

START TIME: 923 END TIME: 955

☑ Continuous cardiac monitor
☐ Refer to Monitor Strip Record

Scope # PCF 140
Electrosurgical Unit: Number: _____
Settings: Cut (bloc. range) _____ Coag. _____
Grounding pad Site: N/A

Assessed by: [signature] RN Patient Response: ☐ No untoward reaction ☐ See "Additional Comments"

RECOVERY

RELEASE FROM OBSERVATION CRITERIA:
☑ Aldrete score 10 or same as pre-proce. score
Time Recovery Completed: 1025

☑ Vital signs stable
☑ Return to pre-procedure alertness
☐ Peds Return to pre-procedure developmental tasks

Assessed by: [signature] RN

POST PROCECURE

Discharge Assessment

Yes	No	N/A	
☑	☐	☐	Able to void/pass flatus
☑	☐	☐	Ambulates without dizziness/nausea
☑	☐	☐	IV removed
☑	☐	☐	No evidence of active bleeding
☑	☐	☐	Comfortable (free of excessive pain)
☑	☐	☐	Able to tolerate and retain liquids
☑	☐	☐	Vital signs stable
☑	☐	☐	Return to pre-procedure alertness

Discharge Instructions
☐ Written discharge instructions given to and understood by ☐ Patient ☐ Responsible adult _____
☐ Belongings returned to patient ☐ N/A
Discharge assessment done by: [signature] RN
☐ Assessment reviewed and concur with findings
☐ Other _____
Signature/title _____

☑ Discharged to home @: _____ with (name/relationship) _____
☐ Transferred to _____ @ _____ accompanied by _____ with (equip) _____
Report to _____

COMMENTS

SIG

Time	Signature/Title	Init	Printed Name	Time	Signature/Title	Init	Printed Name
740	[signature]	[signature]	[signature]	[signature]	[signature]	[signature]	[signature]

PRINTED BY: [illegible]
DATE: 8/22/2007

KERN MEDICAL CENTER
Owned & Operated by County of Kern
Bakersfield, CA

ACCT # 0718000403
PATIENT BIOCINI BEATRIZ ANA
ADMIT DATE 06/29/07

MEDREC # 0001178074
DOB 06/30/54

PHYSICIAN PROCEDURAL SEDATION EVALUATION

Patient ID

Age: 52 yrs Sex ☐ Male ☒ Female Height 5'4 Weight 144#

A. Proposed Procedure: Colonoscopy

B. Present Illness (diagnosis) Bright red blood per rectum

C. Current H&P ☒ In chart. **Note: If current H&P (30 days) is on chart, complete E. – J. ONLY.**
If no H & P in chart complete entire form.

D. Past Medical History	Y	N	Comments/Interval Note
Cardiac Events		X	
Arrhythmia		X	
Pulmonary Disease		X	
Liver disease		X	
Renal insufficiency		X	
Diabetes/Metabolic Disease		X	
Seizures/CNS events		X	
Bleeding disorder		X	
Previous surgery		X	
Possible Pregnancy		X	
Pt./Family hx anesth problem		X	
Alcohol use		X	
Tobacco use		X	
IV Drug abuse		X	

E. Allergies & Sensitivities ☒ NKDA

Current Medications

See allergy form

F. Pertinent Physical Exam: (Check all responses that apply)

Normal? Yes	No		Describe any "Abnormal" responses
☐	☐	Cardiac	
☐	☐	Respiratory	
☐	☐	Neuro	
☐	☐	System Involved	

G. Pertinent Investigations: (Check all responses that apply. Circle WNL as appropriate)
Lab/Diagnostic Tests

○ Hgb/Hct - WNL ○ Other Labs - WNL ○ EKG - WNL ○ CXR - WNL ○ Other Imaging WNL

Comments

H. Assessment ASA Scoring System (circle appropriate one)

1. Normal patient; elective surgery/procedure
2. Mild systemic disease, not activity-limiting
3. Severe systemic disease
4. Severe systemic disease, constant threat to life
5. Moribund patient, not expected to survive without surgery
6. Brain dead; organ donation
E. Emergency

I. Plan of Care: Patient is an appropriate candidate for ☒ Procedure Sedation

Informed Consent:
☒ Risks, benefits, alternatives, potential complications including but not limited to: tooth damage, nerve damage, life threatening events (i.e., MI, CVA, Death) and patient's understanding of and agreement to treatment

J. Completed by: [signature] **ID #** 7480 **Date:** 6/29/07 **Time:** 0835

Original – Medical Record Copy – Quality Resource Center

PRINTED BY: [illegible]
DATE 8/22/2007

AN C:\MYFILES\MEDFORMS\Allen\Phys Procedure Sedation.wpd 11/15/01

5081 99 11/15/2001

ACCT # 0716600392
PATIENT BIOGINI BEATRIZ ANA
MEDREC# 0001178074
DOB 08/30/64

DATE	TIME	ED NEEDS	INFORMATION TAUGHT	WHO	HOW	RESPONSE	SIGNATURE/TITLE
6/15	0815	O	pre/intra & post cool-down sleepy	pt	U	VR	[illegible] RN
6/15	[illegible]	E &	Cardiac monitor [illegible]	pt	U	VR	[illegible] RN
6/15	930	DIC	Discharge instruction post [illegible]	pt	V	VR	[illegible] RN
6/29	740	O	pre intra + post coronary pt		V	V/W	J Cazzell RN
6/29	740	E	monitoring equipment	pt	V	VR	J Cazzell RN
6/29	740	MEDS	Sedation + pain managt	pt	V	VR	J Cazzell RN
6/29	[illegible]	DC	DC + PIV	pt	V W	VR	J Cazzell RN

PRINTED BY: [illegible]
DATE 8/22/07

KMC 561-998-1853 (7/94) Owner: Nursing Approved by Medical Records Committee 9/27/94

SEE SUPPLEMENT FOR MORE INFORMATION ☐

KERN MEDICAL CENTER
1830 Flower St
Bakersfield, CA 93305
Owned and Operated by County of Kern

ACCT # 0716600[illegible]2
PATIENT BIOCINI,BEATRIZ ANA
ADMIT DATE 06/15/07

MEDREC # 0001178074
DOB: 06/30/54

Patient Admission Data Base Inpatient Admissions and Outpatient Surgery

1. **ORIENTATION TO ROOM/SAFETY** (Completed by RN/LVN/NA/MST)
Room Orientation (Check all boxes that apply):
Orientation given to: ☑ Patient ☐ Family ☐ Significant Other ☐ Other
☑ Introductions ☑ ID band ☑ Patient rights ☑ Visiting policy ☑ Bathroom/emergency call system ☐ Bed controls
☐ Bedside console ☐ Smoking policy ☑ Temperature control ☑ TV use and controls ☑ Monitor/Equipment ☐ Infant security

2. **INTRODUCTORY DATA** (Completed by RN/LVN) Date 6/15/07 Time to Floor 815 Room/Bed DIC
updated → 6/29/07 748 815 JC
Check all boxes that apply:
a. Information received from: ☑ Patient ☐ Family _____ ☐ Other _____ Date/Time/Initial 6/15/07 815 JC
b. Admitted from: ☑ Home ☐ ER ☐ Clinic ☐ Other _____
c. Mode of transport: ☐ Gurney ☐ Wheelchair ☐ Ambulance ☐ Other Ambulatory
d. Treatment in progress: ☐ IV ☐ Catheter ☐ Drainage tube ☐ O_2 ☐ Cardiac monitor ☐ Dressings ☐ Other _____
e. Previous admissions: ☑ No ☐ Yes (if <5 yrs, date) _____
Reason for admission per patient _____
f. Primary language: ☑ English ☐ Spanish ☐ Other _____ Understand English? ☐ No ☑ Yes
g. Head circumference (<2 yrs old) _____
h. Verify Acknowledgement Statement is complete ☐ No ☑ Yes ☐ N/A (If NO, complete)
Does patient have an Advance Directive? ☑ No ☐ Yes ☐ N/A If "yes" and copy not on chart, explain intent in Progress Notes ☐ If "no" information given to patient

3. **HEALTH HISTORY** (Completed by RN/LVN) 6/29/07 updated - no change JC
☐ *Unable to acquire at this time (date/initials)* _____ Reason _____
Medical History: ☐ None ☐ Allergy/Medication Sheet completed
☐ Asthma ☐ CVA ☐ Hypertension ☐ Pulmonary Disease ☐ Other _____
☐ Blood Disorder ☐ Diabetes Mellitus ☐ Infectious Diseases ☐ Renal Disorder ☐ Other _____
☐ Bone Disorder ☐ GI Disorder ☐ Jaundice ☐ Seizures
☐ Cancer ☐ Heart Disease ☐ Mental Illness ☐ Skin Disorder
☐ Congenital Anomalies ☐ Hepatitis ☐ Pneumonia ☐ Other _____
a. Previous Surgeries ☐ No ☑ Yes Explain liposuction
b. Immunizations/Exposures: Up-to-Date ☐ No ☑ Yes ☐ Unknown If NO/Unknown, ☐ MD Notified
Tetanus? ☐ No ☑ Yes ☐ Unknown If YES, date of last tetanus shot _____ If NO/Unknown, ☐ MD Notified
Pneumovac? ☑ No ☐ Yes ☐ Unknown If YES, date of pneumovac _____
c. Recent exposure to: ☑ None ☐ Chicken pox ☐ Hepatitis—type ____ ☐ Measles ☐ Meningitis ☐ Mumps ☐ TB ☐ Other, explain
☐ Infection Control notified ☐ MD Notified

4. **HEALTH MANAGEMENT PATTERN** (Completed by RN/LVN) 6/29/07 updated - Ø changes JC
a. Personal Habits ☐ Denies
Caffeine use Ø
Alcohol use occasional ☑ Tobacco use Quit 95 ☑ Street drug use _____
Write in type and amount per day _____
Have you ever been in a treatment program? _____
b. Sensory: ☐ None
Hearing aid ☐ Left ☐ Right ☑ Glasses ☐ Contacts
☐ Dentures: ☐ Upper ☐ Lower ☐ Caps ☐ Bridge
☐ Other _____
Comments _____

5. **BASELINE INFORMATION** (Completed by RN/LVN) History of Following 6/29/07 updated - Ø changes JC
a. Circulation ☑ Denies history of
☐ Palpitations ☐ Chest pain
☐ MI ☐ Heart trouble
☐ Heart murmur ☐ Mitral valve prolapse
☐ Swelling ☐ Hands ☐ Feet ☐ Numbness or tingling
b. Respiration ☑ Denies history of
☐ Difficulty breathing
☐ Required oxygen
☐ Special positions to help your breathing
c. Elimination ☐ Denies history of
☐ Laxatives ☐ Hemorrhoids
☐ Blood in urine ☐ Rectal bleeding
☐ Trouble urinating cramps pain
d. Neurological ☑ Denies history of
☐ Syncopal episodes
☐ Weakness in extremities Arm: ☐ Left ☐ Right Leg: ☐ Left ☐ Right
e. Pain/Comfort Assessment ☐ Unable to obtain from patient/family ☑ Denies history of
☐ Problems with pain ☐ Recent ☐ Remote (Document current pain or daily assessment)
When you have pain describe the following: Location of pain _____ Pain intensity on a scale of 1 to 10
Quality of pain: ☐ Sharp ☐ Stabbing ☐ Dull ☐ Tingling ☐ Constant ☐ Intermittent ☐
Onset of pain _____ Aggravating factors _____
Comfort measures used to relieve pain: _____

ACCT#0718000403 MEDREC 0001178074
BIOCINI,BEATRIZ ANA
SDS DATE: 06/29/07 DOB: 06/30/54 SEX: F

ACCT # 0716600392
PATIENT BIOCINI BEATRIZ ANA

MEDREC# 0001178074
DOB 08/30/64

6. SPECIFIC POPULATIONS (Completed by RN/LVN) History of following:

a. Pediatric ☐ N/A
- ☐ Normal cry
- ☐ Jaundice
- ☐ Suck reflex
- ☐ Abdomen soft
- ☐ Abdomen extended
- Fontanelle: ☐ Soft ☐ Flat ☐ Sunken ☐ Bulging
- History of breathing: ☐ apneic episodes ☐ Turn blue

Number of meals/day:
Self feeding: ☐ No ☐ Yes ☐ Needs assistance
Diet: ☐ Formula ☐ Baby food/cereal ☐ Regular
☐ Special diet _____
Drinking methods: ☐ Breast ☐ Bottle ☐ Cup ☐ Straw
Feeding routines: _____
☐ Toilet trained ☐ Wets bed at night only
Number of wet diapers/day: ☐ N/A _____
☐ Self toileting ☐ Needs assistance Comments _____

Behavior/Development Milestones by Child
- ☐ Rolls over
- ☐ Assists with dressing self
- ☐ Sits alone
- ☐ Can follow directions
- ☐ Stands alone
- ☐ Hops/jumps/runs
- ☐ Attends school Where _____
- ☐ Walking – self
- ☐ Writes name
- ☐ Points to named body part
- ☐ Knows name and address
- ☐ Talking—5 or more words

Discharge Planning Peds
Patient lives with:
☐ Father ☐ Mother ☐ Parents ☐ Friend ☐ Foster care
Who is the guardian? _____ ☐ Copy on chart
Where will the child go after discharge?
☐ Home ☐ Other _____
Who will care for the child after discharge? _____
Who will help you and the child if you need it? _____
What is the parents' expectation of involvement in the treatment and care of the child? _____

b. **Labor & Delivery/Pregnancy** (Completed by RN/LVN)
☑ N/A
Prenatal history form on admission ☐ No (pre-admit) ☐ Yes
EDC _____ By: ☐ LMP ☐ U/S @ _____ wks
Age _____ Gravida _____ Para _____
AB _____ Term _____ Preterm _____
Number of living children _____

☐ Prenatal care ☐ Current complaints
☐ Complications this pregnancy ☐ Complications other pregnancies
☐ Medical problems
Explain _____
When did you last feel baby move?
Date _____ Time _____

7. BIOPHYSICAL ASSESSMENT (See Patient Flow Sheet for System Assessment) (Completed by RN)

8. DISCHARGE PLANNING (Completed by RN/LVN) 6/29/07 updated - no changes JL
☐ Primary physician _____ ☐ None Phone Number _____
☑ Home environment: Physical access problem? ☑ No ☐ Yes Water/electric available? ☐ No ☑ Yes
☐ Highlight anticipated discharge needs (equipment/supplies/none): _____
☐ Anticipated agencies for follow-up (Home Health/Meals on Wheels) Transportation/None _____
Concerns:
☐ Address correct If NO, Address & Phone No. verified for Discharge: _____

9. PRE-OP SCREENING (Completed by RN) ☐ N/A
V/S Temp 97.9 Pulse 92 Resp. 18 99% B/P 105/79 Age 52
Surgery/Procedure Scheduled Colonoscopy
☐ Driver present ☐ N/A Name Inmate Phone Number _____
● Circle all appropriate numbers. Record total for each section. Record cumulative total.

Unable to walk up one flight of stairs or one mile without SOB or chest pain	6	Thyroid disease	6
Recent cold or infections	6	Patient concerns or expectations regarding anesthesia	6
Cough/sore throat	6	History of anemia	6
Limitations to neck or jaw movement	6	Hiatal hernia/heartburn/epigastric pain	6
History of difficult intubation	6	Bleeding tendency	8
Complications or reactions to anesthesia	8	Special diet	6
Family history of anesthesia problems	6	Nausea/vomiting	6
Reaction to blood transfusion or blood products	6		

* Refer for score of 6 or greater. Will inform MD Total 6

Sign for Outpatient Only:

6/15/07 PRINTED BY: [illegible] DATE: 6/22/2007

Date 6/29/07 Time 740 Signature [signature] RN

MISD

KERN MEDICAL CENTER
1700 MOUNTAIN VIEW DRIVE
BAKERSFIELD CA 93305-4191

ACCT#0718000403 MEDREC 00011/8074
BIOCINI BEATRIZ ANA
SDS DATE 06/29/07 DOB 06/30/54 SEX F

OUTPATIENT STANDARDS OF CARE POST-OPERATIVE AND POST-PROCEDURAL

OUTCOME STANDARDS

1) The patient will demonstrate stability in hemodynamic status and physical comfort
2) The patient will verbalize appropriate orientation and feelings of understanding towards anesthesia, surgical or procedural experience
3) The patient or guardian will verbalize comfort and well being for discharge.
4) The patient/significant other will repeat understanding of discharge instructions

Date Met: 6/29/07 Signature: JCazzell RN M053

TIME	INITIAL	NURSING DIAGNOSIS	INTERVENTIONS	DISCONTINUED TIME	DISCONTINUED INITIAL
1005	JC	1. Altered respiratory function related to anesthetic, surgical intervention, narcotic, or airway obstruction.	1 Assess respiratory status every 15 min x 2 and prn as per hospital policy/physician order: a Resprate c. Airway patency b Breath sounds d. SpO_2 2. Administer oxygen if ordered and record SpO_2 reading. Notify MD if SpO_2 less than 92% on room air 3. Assess and encourage deep breathing and coughing initially and every 30 minutes x 2. 4. Suction as needed. 5. Notify MD if inadequate respiratory function.	1025	JC
1005	JC	2. Altered cardiovascular function related to drug administration, surgical intervention, hypovolemia.	1 Assess cardiovascular status and every 15 min x 2 and prn as per hospital policy/physician order. a. Heart rate c. Observe dressing and drains b. Blood pressure 2 Notify MD of changes with: a Heart rate less than 40, greater than 120 (adult) b BP less than, or greater than 20-50 mm/Hg of pre-op BP c Refer to Standards of Practice Day Hospital Specific #10173.00 Addendum (Pediatric). 3. Administer fluids and/or blood as ordered 4. Assess temp and color of skin on admission, discharge and prn 5. Document I & O on admission, discharge and prn 6. Assess peripheral circulation on admission, discharge and prn.	1025	JC
1005	JC	3. Alteration in body temperature related to heat loss intraoperatively.	1 Assess initially and every 30 min and prn for temp less than 96° or greater than 100° 2 Provide warming blanket as needed.	1025	JC
1005	JC	4. Alteration in comfort related to surgical intervention.	1 Assess initially and prn. 2. Position for comfort. 3. Administer pain medication as ordered	1025	JC
1005	JC	5. Impairment of mobility related to anesthetic, drug administration.	1. Assess initially and every 15 min x 2. 2. Position body in alignment and for safety. 3. Assess and document the strength of lower extremities 4 Dangle and ambulate prn 5 Provide support and good alignment for affected extremities	1025	JC
1005	JC	6. Altered level of consciousness related to anesthetic.	1 Assess initially and at discharge and prn 2 Solicit orientation to person, place, time, purpose, and reorient as needed. 3 Solicit feelings of comfort and feelings of well-being.	1025	JC
1005	JC	7. Knowledge deficit related to post anesthesia/surgical home care needs (outpatient)	1 Discuss home care instructions with client and significant other. 2. Solicit verbal repetition of specific care aspects, i.e., signs of infection, follow up appointment, deep breathing and coughing 3 Provide other specific instruction of physician preference 4 Provide copy of signed instructions	1025	JC
1005	JC	8 Potential for injury related to loss of voluntary movement.	1 Maintain side rails up 2 Apply safety belt. 3 Pads de rails as needed i.e., pediatric. 4 Provide reassurance verbally and manually	1025	JC
		9. Other			

Signature: _____ DATE: 6/29/2007 Signature: MHRhodes M7845 RN

KMC 580 693/ 1711 (4/02) (Back)

KERN MEDICAL CENTER
BAKERSFIELD CA 93305 4197

ACCT#0718000403 MEDREC 00011780?A
BIOCINI,BEATRIZ ANA
ADMIT DATE: 06/29/07 DOB 06/30/54 SEX F

OUTPATIENT STANDARDS OF CARE PRE-OPERATIVE AND PRE-PROCEDURAL

OUTCOME STANDARDS

1) The patient will demonstrate physiological stability in hemodynamic status and physical comfort
2) The patient and/or significant other will verbalize a readiness for surgical intervention.
3) The patient and/or significant other will verbalize knowledge of the per-operative process

Date Met 6/29/07 Signature:

TIME	INITIAL	NURSING DIAGNOSIS	INTERVENTIONS	DISCONTINUED TIME	DISCONTINUED INITIAL
740		1. Anxiety related to unfamiliar environment, knowledge deficit; fear of pain and change in lifestyle.	1. Explain OR and PACU procedures to patient and significant others. 2. Encourage patient and significant others to verbalize concerns and questions. 3. Approach child with age appropriate method to orient patient 4. Orient, support and provide reassurance.	745	
740		2. Knowledge deficit related to routine procedures associated with surgery; preparation for surgery; post op care.	1. Explain peri-op events to patient and significant others 2. Assess discharge needs. 3. Initiate activities towards resolution of post-operative needs. 4. Provide information regarding pain control and necessary monitoring activities.	745	
740		3. Potential for alteration in fluid volume related to NPO status	1. Obtain pre-op vital signs on the day of surgery. 2. Obtain IV access and check for IV patency. 3. Review lab values as ordered. 4. Verify duration of NPO status.	745	
		4. Other (Please list).	1. Other (Please list).		

Signature: _____ RN Signature _____ RN

PRINTED BY: [illegible]
DATE 8/22/2007

KERN MEDICAL CENTER
Owned and Operated by the County of Kern
1830 Flower Street
Bakersfield, CA 93305 (661) 326-2000

ACCT#0718000403 MEDREC 00[illegible]78074 Date

BIOCINI,BEATRIZ ANA
DOS DATE: 08/29/07 DOB: 06/30/54 SEX: F

[redacted]

CAL RECORD #

Cardiac Rhythm

Hemodynamic Status/Vital Signs

PRE-PROCEDURE

PROCEDURE

Temp F | BP HR

105 190
104 180
103 170
102 160
101 150
100 140
99 130
98 120
97 110
96 100
95 90
94 80
93 70
92 60
91 50
90 40
89 30
88 20
87 10
86 0

HR
O2
Resp
T
BP
MAP

PAIN INTENSITY

10
5
0

Relief Acceptable (Y/N)

Pain Intervention

Pulse Ox SaO_2

FIO_2 L/M or % O

INTAKE

1
2
Meds
Blood/blood prod
PO/Total
NG/OG/Total

OUTPUT

Urine: Amt oc/Total
Drain/Aspirate
Drain
Stool: Sml/Loose type
Other

PAIN INTERVENTION KEY: A - Analgesic N - Narcotic R - Reposition T - Titrate C - Compress O - Other(See Flowsheet Notes)

ATTACH EKG STRIP (IF APPLICABLE)

INTERPRETATION: [redacted]

DATE: 8/29/2007

[redacted]

14-1358 (02/04)

TIME IN _____ ALLERGIE

TIME OUT _____ NPO SINCE _____

ACCT 0718000403 MEDREC 0001178074
BIOCHNI,BEATRIZ ANA
SDS DATE 06/29/07 DOB 06/30/54 SEX F

RECOVERY

Temp °F	BP / HR
105	190
104	180
103	170
102	160
101	150
100	140
99	130
98	120
97	110
96	100
95	90
	80
	70
	60
	50
	40
	30
	20
	10
	0

INVASIVE SITE / TYPE	Dsg	Bandage Y N	Insert Date	Tubing	Int

ENDOSCOPE _____

EQUIPMENT / ACCESSORIES USED _____

☐ Forceps ☐ Snare ☐ Heater Probe ☐ Hot Box

CAUTERY SETTING CUT _____ COAG _____

PAD SITE _____

Dilatation Type: ☐ NA Type _____ Sizes _____

Fluoro Time _____ min Contrast: Type / Amt _____ ☐ NA

Pathology:

☐ None
☐ H. pylori _____
☐ Time _____
☐ Biopsy _____
☐ Biopsy _____
☐ Polyp _____
☐ Other

Specimens to Lab: ☐ Yes ☐ NA

STANDARDS OF CARE 6/29/07

Outcome Standards: **MET BY:**

The patient will demonstrate physiologic stability in hemodynamic status and physical comfort during procedure

NURSING DIAGNOSIS	INTERVENTION
1. Potential for alteration of level of comfort related to procedure.	1. Advise physician of pain or of increased level of physiological response. 2. Administer medications as ordered.
2. Potential for reaction related to drugs.	1. Implement EKG, SpO_2, & V/S, per standard.
3. Potential for ineffective coping related to fear of unknown	1. Explain procedures 2. Encourage to express feelings. 3. Provide verbal/non verbal reassurance.
4.	4.

INTAKE

- IV Fluids
- IAL
- Lipids
- Blood/Blood Products
- PO Intake
- *Total Intake

OUTPUT

- Urine
- Stool
- NG/OG
- *Total Output

PRINTED BY: _____

DATE: 06/29/2007

RN _____

Endoscopy Tech _____

Radiology Tech _____

Physician _____

PRE-PROCEDURE

RECOVERY

Pg 3 of

ACCT#0718000403 MEDREC# 0001178078
BIOCINI,BEATRIZ ANA
SDS DATE: 06/29/07 DOB 06/30/54 SEX F

NEUROLOGICAL
Time / Initials
Oriented X 3
Behavior appropriate
PERLA
Active ROM X 4 symmetrical strength
Speech clear, appropriate

CARDIOVASCULAR
Time / Initials
NSR Rate
Extrem warm, pink
Capillary refill < 3 sec
Peripheral pulses palpable

RESPIRATORY
Time / Initials
Equal symmetrical chest expansion
Resp. quiet & reg in rate/depth
Clear breath sounds all lexds
Nailbeds, membranes pink

GASTROINTESTINAL
Time / Initials:
Abdomen soft/flat/non-tender
Active bowel sounds
Tol diet w/o nausea/vomiting
BM within usual pattern/consistency
Normal appetite, chewing
Swallows without difficulty

GENITO-URINARY
Time / Initials
Voids without pain, frequency or incontinence
Normal urine color, odor

MUSCULO-SKELETAL
Time / Initials
Full ROM strength equal bilateral
Steady gait, coordination

SKIN
Time / Initials
Skin color/turgor normal
Skin warm, dry, intact
Mucous membranes moist
IV site is R/S/T

PSYCHOSOCIAL
Time / Initials:
Stable living situation
Stable support system
Mood/affect appropriate

PAIN
Time / Initials
Location
Duration
Characteristic (Stabbing, dull)

DATE 06/29/2007

Init	Signature	Title	Shift	Int

ACCT#0718000403 MRN: 00011/8074
BIOCINI,BEATRIZ ANA
SOS DATE: 08/28/07 DOB: 06/30/64 SEX:

Weekend nurse RN Dept

Time	Discipline

FLOWSHEET NOTES (Record pt events, tests, procedures)

OUT-PATIENT CALL BACK

Date of Procedure: _____

Physician _____

Procedure: _____

Comments: _____

Current Phone # _____

Nurse's Signature _____ R.N./L.V.N. Date: _____

	YES	NO	N/A	COMMENTS
Tolerating Fluids/Nourishment				
Nausea/Vomiting				
Dressings, Any Drainage				
Headache/ nasional Pain/Sore Throat				
Pain Medication Taken				
Voided				
Blood Tinged Urine				
Extremity Circulation				
Refer to Anesthesia				
Refer to Attending Physician				
ABD Discomfort				
Rectal Bleeding				
Coughing up Blood				

Comments: _____

PRINTED BY: [illegible]
DATE 8/22/2007

Nurse's Signature _____ R.N./L.V.N. Date _____

KERN MEDICAL CENTER
OWNED AND OPERATED BY THE COUNTY OF KE
1830 Flower Street
Bakersfield, CA 93305
(661) 326-2000

ACCT#0718000403 MEDREC 0001178074
BIOCINI,BEATRIZ ANA
SDS DATE: 06/28/07 DOB 06/30/54 SEXF

POST-PROCEDURE DISCHARGE INSTRUCTIONS

Your procedure Colonoscopy

Your Doctor Dr. Wong

Diet:
- ☐ Nothing to eat or drink for _____ hour
- ☐ _____ diet for _____ hours
- ☑ Resume regular diet after 1 hours
- ☐ No alcoholic beverages for 24 hours
- ☐ Increase fluid intake for next 24 hours

Activity:
- ☐ Bedrest for 24 hours (may use bathroom)
- ☑ Limit activity for 24 hours
- ☐ Elevate head for _____ hours
- ☑ Do not make important personal or business decisions for 24 hours
- ☑ Do not drive or operate hazardous equipment for 24 hours
- ☑ Do not bend, strain, or lift heavy objects for 24 hours
- ☑ Resume regular activities on 6/30/07

Hygiene:
- ☐ Sponge bath until 6/30/07 then resume regular bathing routine
- ☐ Resume regular bathing routine
- ☐ Good oral hygiene routine

Wound Care:
- ☐ Leave dressing in place until _____
- ☐ Leave open to air
- ☐ Keep site clean and dry

Precautions:
- ☐ Monitor incision/puncture site for possible bleeding
- ☐ Hold pressure on puncture site when you cough, sneeze, or stand up
- ☑ Dizziness is not unusual, be careful when walking, climbing stairs, or driving

Medications:
- ☐ None
- ☐ Prescriptions sent with patient
- ☐ Do not take any medications that have not been specifically prescribed for you
- ☑ Continue previous medications
- ☐ Hold _____ for _____ days

Medication Metamucil Dose _____ How often daily X 30 days Purpose constipation

Medication _____ Dose _____ How often _____ Purpose _____

Medication _____ Dose _____ How often _____ Purpose _____

PRINTED BY: [illegible]

Original - Chart Copy - Patient [illegible]

Owner DTC
Approved by Medical Records Committee 1/27/04

ACC #07180000403 MEDREC 00011780174
BIOCINI,BEATRIZ ANA
SDS DATE 06/29/07 DOB 06/30/54 SEXF

☐ **Safe and Effective Use of Medical Equipment:**
- ☐ PICC line care
- ☐ Other (specify) _____

☐ **Special Instructions:**
Call 326-2667 or come to the Emergency Room Immediately if any complications develop
- ☐ Chills or fever over 101°
- ☐ Signs of infection: increasing pain, redness around the incision, foul odor or drainage from the incision
- ☐ Bleeding from the incision, frank red blood or oozing that saturates the dressing
- ☐ Persistent nausea or vomiting
- ☐ Persistent abdominal pain
- ☐ Coughing up more than 1-2 teaspoons of blood
- ☐ Difficulty breathing persistent dizziness
- ☐ Fever headache not relieved by your usual medications
- ☐ Chest pain or pressure in your chest
- ☐ Difficulty in arousing

☐ **Community Resources:**
- ☐ If you have any questions call 326-2807 Monday thru Friday, 8:00am to 4:00 pm

☐ **Next Appointment:**

Clinic Red Surgery Date 7/12/07 Time 1:00P Phone number _____

Clinic _____ Date _____ Time _____ Phone number _____

Clinic _____ Date _____ Time _____ Phone number _____

☐ **I have received as well as demonstrated my understanding of the discharge instructions given**

X _____ IEA _____ _____ RN 7845 6/29/07 1025
Patient/Guardian's signature Nurse's signature Date/Time

Care Notes:

☐ _____

Original – Chart Copy – Patient PATIENT ID: [illegible]
Owner: DTC DOT: 8/22/2007
Approved by Medical Records Committee 7/27/04

RMC 560 Ev97 2119 (1 04)

KERN MEDICAL CENTER
1830 FLOWER ST.
BAKERSFIELD, CA. 93305

CLINIC RECORD NOTES

ACCOUNT NO: 0716600392 | DATE ARRIVED: 08/15/07 | TIME: 06:37 | ARRIVAL MODE | PT CLASS | LOCATION: END | MEDICAL RECORD NO: 0001178074

PATIENT
NAME: BIOCINI,BEATRIZ ANA
STREET ADDRESS: 17635 INDUSTRIAL FARM RD | CITY: BAKERSFIELD | STATE: CA | ZIP: 00003
PHONE: (000)391-7913 | SOC SEC NO: 000-00-0001 | MARITAL STATUS | BIRTHDATE: 06/30/54 | AGE: 52Y | SEX: F
INS: BK#1709304 | POL NO | FINANCIAL CLASS: J COUNTY CORRECTIONA
EMERGENCY NOTIFY | HOME PHONE | PO NO | BUSINESS PHONE
MANAGED CARE/HMO: ☐ Yes ☐ No | AUTHORIZED: ☐ Yes ☐ No | TIME | HMO PERSON AUTHORIZING
TETANUS IMMUNIZATION: ☐ UP TO DATE ☐ NOT UP TO DATE | LANGUAGE
CONDITION UPON ARRIVAL: ☐ CONSCIOUS ☐ UNCONSCIOUS | CHART ORDERED (TYPE OR MD ALTO) | TIME RECEIVED (IF NO RELATED)
TRIAGE CATEGORY: ☐ WALK IN ☐ APPOINTMENT ☐ LIFE THREATENING ☐ URGENT ☐ EMERGENCY ☐ ISOLATION ☐ DROP ☐ LB

CHIEF COMPLAINT/PROBLEM: COLONOSCOPY @ 800A
PRIMARY CARE PHYSICIAN | ALLERGIES

OBJECTIVE FINDING:	TIME	WEIGHT	HEIGHT	TEMP	PULSE	BLOOD PRESSURE	RESPIRATION	HEAD CIRC...M	NURSE/ORTHO TECH

TIME SEEN: 06/15/07 - 09:00

S: Pt seen today Admitted to having eaten 1/2 cup of oatmeal this AM & had a BM She's schedulad for a colonoscopy today.

A/P: We will have to Re schedule Mrs Biocini's colonoscopy in order to have the optimal result & visualization.
- Pt re-instructed on what she needs to do.
- Will re-order bowel prep
- Will re schedule colonoscopy.

9774

DISABILITY
ICD DCM | FINAL DIAGNOSIS

DOCTOR'S SIGNATURE | DISPOSITION OTHER THAN HOME
FACILITY REVIEW | PATIENT TO ATTACH AFTER CARE INSTRUCTIONS

PRINTED BY: 10116
DATE 8/22/2007
MEDICAL RECORDS

medatrans® 2.0 rev. ada 5006 BG 8/22/2000

KERN MEDICAL CENTER
Owned and Operated by the County of Kern
Bakersfield, CA 93305

ACCT# 0716600[illegible]2 MEDREC# 0001178074
PATIENT BIOCINI,BEATRIZ ANA

DOB 06/30/54

ADMIT DATE 06/18/07 ADMIT TIME 06:37

PHYSICIAN ORDERS - MEDICATION RECONCILIATION - ALLERGIES

Date: 6/15/07

Scan to Pharmacy prior to patient orders

All applicable areas, including height and weight, must be completed.

Height 5' 4" ☐ Inches ☐ Centimeters Weight [illegible] ☐ Lb ☐ Kg ☐ Bed scale ☐ Standing ☑ Other Stated

Women only Are you pregnant? ☐ Yes ☑ No Are you Breast Feeding? ☐ Yes ☑ No

ALLERGIES (such as medicine, latex, food, tape, soap, perfumes

☑ No Known Allergies ☐ Unable to obtain from patient/family ☐ Patient banded with Allergy band and chart labeled

ALLERGEN	TYPE OF REACTION (write all reactions)

Are you taking your medicine as prescribed? ☑ Yes ☐ No If No, explain

☐ Med List Incomplete because: ☐ Poor historian or lack capability ☐ Meds unavailable ☐ Takes no medications

NURSING RESPONSIBILITY (may be completed by Physician or Pharmacist)

MEDICATIONS: List **ALL** medications on admission (Prescriptions, OTC, Herbals, Patches, Inhalers, Eye Drops, Supplements)

PHYSICIAN RESPONSIBILITY

PHYSICIAN MEDICATION ORDERS on ADMISSION (check only one)

NAME OF MEDICINE (print legibly)	DOSE (mg, mcg)	ROUTE	FREQUENCY (daily, twice daily, four times daily, etc)	Order UNCHANGED	CHANGE (Use Order Sheet)	DO NOT ORDER
lactulose	liquid	p.o.	daily	☐	☐	☐
Colace	2 tabs	po	pm	☐	☐	☐
benadryl	1 tab	po	p.m	☐	☐	☐
Sleeping pill	1 tab	po	hs	☐	☐	☐
				☐	☐	☐
				☐	☐	☐
				☐	☐	☐
				☐	☐	☐
				☐	☐	☐
				☐	☐	☐
				☐	☐	☐

Medication history collected and verified with ☐ patient/ ☐ family by

Signature (RN/LVN/MD/RPh) [illegible] 6/15/07 Date 0815 Time

I have reviewed this list:

Physician Signature 6/29/07 Date 1015 Time

Disposition of Meds: ☐ Pharmacy ☐ Patient ☐ Family ☐ Police

Name of Receiving Party:

Original To Chart Scanned to Pharmacy
Date Time: By

Original To Chart Scanned to Pharmacy
Date

KMC 5092 Owner: Pharmacy (Approved by Medical Records Committee 9/22/2005)

ACCT#0718000403 MEDREC 0001178074
BIOCINI,BEATRIZ ANA
SDS DATE: 06/29/07 DOB 06/30/54 SEXF